Matthew D. Gemp, D.M.D.

Patient Information (CONFIDENTIAL)

Date _____

Soc. Sec. # _____

Birthdate _____

Name _____ *Home Phone* _____ *Cell Phone* _____

Address _____ *City* _____ *State* ____ *Zip* _____

E-mail: _____

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married*

If Student, Name of School / College _____ *City* _____ *State* _____ ☐ *Full Time* ☐ *Part Time*

Patient's or Parent's Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State* ____ *Zip* _____

Spouse or Parent's Name _____ *Employer* _____ *Work Phone:* _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ *Phone* _____

Responsible Party

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Address _____ *Home Phone* _____

Driver's License # _____ *Birthdate* _____ *Financial Institution* _____

Employer _____ *Work Phone* _____ *SSN#* _____

Is this person currently a patient in our office? ☐ *Yes* ☐ *No*

IT IS THE POLICY OF THIS OFFICE TO MAKE DEFINITE FINANCIAL ARRANGEMENTS BEFORE ANY MAJOR WORK IS STARTED. IN ALL CASES REQUIRING LAB WORK SUCH AS CROWNS, DENTURES, OR BRIDGES WE REQUEST A MINIMUM DOWN PAYMENT OF 50%.

Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *Social Security #* _____ *Date Employed* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy / ID #* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

Insurance Company Phone # _____ *How much is your deductible?* _____ *Max. Annual Benefit* _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

x _____

Signature of patient (or parent if minor)